An Overview of Your Health Care Benefits

For employees of

Lancaster County

Administered by

BlueCross BlueShield of Nebraska

A Not-For-Profit Mutual Insurance Company and an Independent Licensee of the Blue Cross and Blue Shield Association.

THE VALUE OF BLUE

Welcome to Blue Cross and Blue Shield of Nebraska! As one of our valued members, you enjoy these and other advantages:

- ✔ Access to Nebraska's largest provider network
  - 100% of nongovernmental acute care hospitals
  - 93% of Nebraska physicians
  - Rx Nebraska pharmacy network includes nearly 56,100 pharmacies nationwide, with more than 450 located in Nebraska.
- ✔ Access to network hospitals and doctors nationwide and around the world through the BlueCard Program.
- ✔ Fast and accurate claims processing. We process more than 90% of all claims in two weeks or less. In 2004, we processed 12.1 million claims with 99.9% accuracy.

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Lancaster County PPO Benefit Plan

	In-Network	Out-of-Network
Overall contract benefit maximum	$2 million per person	
Calendar year deductible		
Individual	$250	$250
Family maximum	$500	$500
Calendar year coinsurance maximum		
Individual	$500	$1,250
Family maximum	$1,000	$2,500
Coinsurance you pay for most covered services	10% of allowable charges	20% of allowable charges
Physician office visit *Diagnostic and routine care*	$15 copay per visit	Benefits subject to deductible and coinsurance
Preventive/routine services *Excluding office visit charge; paid as shown above*	Covered services paid at 100% of allowable charge	Benefits subject to deductible and coinsurance
Routine vision exams	$15 copay	Benefits subject to deductible and coinsurance
Emergency room and urgent care facility benefits		
Emergency room facility charges	$100 copay (waived if admitted within 24 hours for same diagnosis)	
Emergency room physician charges	Covered services paid at 100% of allowable charge	
Urgent care facility charges	$35 copay per visit	
Ambulance services	Benefits subject to in-network deductible and coinsurance	
Physical, occupational and speech therapy/cognitive training; chiropractic/osteopathic sessions *Benefits are subject to a combined maximum of 75 therapy sessions per calendar year*	$15 copay per visit	Benefits subject to deductible and coinsurance
Outpatient cardiac or pulmonary rehabilitation *Benefits are subject to an 18-session maximum each calendar year*	$15 copay per visit	Benefits subject to deductible and coinsurance
Inpatient mental illness and/or substance abuse treatment *Benefits (excluding serious mental illness) are subject to a 30-day calendar year maximum*	Benefits subject to deductible and coinsurance	Benefits subject to deductible and coinsurance
Outpatient mental illness and/or substance abuse treatment *Benefits (excluding serious mental illness) are subject to a 20-unit maximum per calendar year*	$15 copay	Benefits subject to deductible and coinsurance
Prescription drug copays		
Retail, per 30-day supply		
Generic	$10	$10 + 25% penalty
Formulary brand name	$25	$25 + 25% penalty
Non-formulary brand name	$40	$40 + 25% penalty
Diabetic and ostomy supplies, injectable medications, needles, syringes, alcohol wipes, glucose monitors and insulin pump supplies	10% of allowable charge	10% of allowable charge + 25% penalty
Mail service, per 90-day supply		
Generic	$25	N/A
Formulary brand name	$62.50	N/A
Non-formulary brand name	$100	N/A
Diabetic and ostomy supplies, injectable medications, needles, syringes, alcohol wipes, glucose monitors and insulin pump supplies	10% of allowable charge	N/A

A Health Care Plan Exclusively For Lancaster County Employees

This document provides you with an overview of the Blue Cross and Blue Shield of Nebraska **Blue***Preferred* PPO plan offered to Lancaster County employees. **This is not a contract. It is intended as a general overview only. It does not contain all the details of this coverage.** For more complete information, including benefits, exclusions and contract limitations, please contact your employer.

The BluePreferred Provider Network

What's a PPO?

PPO stands for *preferred provider organization.* PPOs are special arrangements between insurers and a network of hospitals, doctors and other types of providers to pay for health care services. As a result of these arrangements, you save money, because in most cases, you pay less in deductible and coinsurance when you use PPO network hospitals, doctors and other health care professionals.

The **Blue***Preferred* PPO network is the largest in the state -- made up of 93% of the state's doctors and 100% of non-governmental acute care hospitals. So chances are good that your doctors and hospitals are **Blue***Preferred* providers.

Blue*Preferred* hospitals, doctors and other health care professionals have agreed to accept Blue Cross and Blue Shield of Nebraska's benefit amount for covered services as payment in full, except for any deductible, coinsurance and copay amounts and charges for noncovered services, which are your responsibility. **Blue***Preferred* providers also file your claims for you, meaning you have less paperwork to worry about. Benefit payment is sent directly to **Blue***Preferred* providers.

How to locate BluePreferred PPO providers in Nebraska

On the Web: **www.bcbsne.com**
By phone: (402) 390-1820 or 1-800-642-8980

The BlueCard Program

You have access to PPO providers nationwide through the **BlueCard** Program.

To access your benefits wherever you are, all you have to do is use hospitals and doctors in the local Blue Cross and Blue Shield Plan's **BlueCard** PPO network. When you do, you also enjoy the discount and claim filing agreements Blue Cross and Blue Shield Plans across the country have negotiated with the **BlueCard** network doctors and hospitals in their area.

How to Locate BlueCard PPO Providers Nationwide

It's easy to locate **BlueCard** Program PPO hospitals, doctors and other health care professionals wherever you are.

On the Web: **www.bcbs.com**
By phone: **1-800-810-BLUE (2583)**

Important Information About Your Plan

Maximum Benefits

$2 million benefit maximum per covered person.

Calendar Year Deductible

If you're covered under single membership, you must satisfy one individual deductible each calendar year. The family deductible is equal to two times the individual deductible. Family members may combine their covered expenses to satisfy the required deductible amount. No one family member pays more than the individual deductible amount.

Please note: The calendar year deductible applies to most covered services, unless otherwise noted. Copay amounts under this plan do not apply toward satisfaction of the calendar year deductible.

Your Coinsurance and the Calendar Year Coinsurance Maximum

After you have met your calendar year deductible, you are responsible for paying a certain percentage of covered charges (called "coinsurance") until you reach your coinsurance maximum. Once you reach your coinsurance maximum, you pay nothing for most covered services for the rest of the calendar year. Coinsurance for treatment of non-serious mental illness and/or substance abuse does not apply toward the coinsurance maximum.

Please note: Copay amounts under this plan do not apply toward satisfaction of the calendar year coinsurance maximum.

Inpatient Notification & Certification

Important: When possible, certification/notification as described below should be completed prior to the inpatient admission. **If certification/notification does not take place when required, available benefits for covered services will be reduced by 50%.**

Notification

Blue Cross and Blue Shield of Nebraska must be notified of all medical/surgical inpatient hospital admissions. This enables us to coordinate discharge planning, case management, and disease management services with the patient's providers. If the patient is hospitalized in a contracting **Blue***Preferred* hospital in Nebraska, notification will be provided by the hospital.

If the patient is hospitalized in a non-**Blue***Preferred* hospital in Nebraska or is admitted to an inpatient facility in another state, Blue Cross and Blue Shield of Nebraska must be notified by you, the physician or the hospital.

Certification

Benefits must be **precertified** for the following inpatient care, regardless of where the care is received, in- or out-of-network:

- Mental illness and/or substance abuse treatment
- Physical rehabilitation
- Long term acute care
- Skilled nursing facility care

Notification/certification of benefits for an inpatient admission:

call (402) 390-1870 or 1-800-247-1103

Prescription Drug Coverage

To locate participating Rx Nebraska pharmacies nationwide, call toll-free 1-877-800-0746.

Your coverage is based on Blue Cross and Blue Shield of Nebraska's drug formulary. A formulary is a list of generic and brand name prescription medications that Blue Cross and Blue Shield of Nebraska's Pharmacy & Therapeutics (P&T) Committee, considers safe and effective for care. Members of the P&T Committee are practicing physicians and pharmacists who meet regularly to review medications.

Under this plan, prescription drug benefits are divided into three categories, or tiers: generic drugs, brand name drugs that are listed in the formulary and brand name drugs that are not in the formulary. The copay amount you pay for up to a 30-day supply of a covered prescription drug depends on what tier your medication is in.

Note: The copay amount for diabetic and ostomy supplies, injectable medications, needles, syringes and alcohol wipes and glucose monitors and insulin pump supplies is 10% of the allowable charge.

To review the drug formulary online, go to: **www.bcbsne.com/members/drugformularies.asp.**

Retail

		per 30-day supply
Tier 1	Generic drugs	$10
Tier 2	Formulary brand name drugs	$25
Tier 3	Non-formulary brand name drugs	$40

To use your prescription drug benefits, take your Blue Cross and Blue Shield of Nebraska I.D. card and your prescription to an Rx Nebraska participating pharmacy and pay the applicable copay amount for each 30-day supply. If allowed by your prescription, you may obtain up to a 90-day supply of your medication at one time by paying three copays.

If you have your prescription filled at a nonparticipating pharmacy, or if you don't present your card at a participating pharmacy, you will need to file an Rx Nebraska claim. You'll be reimbursed the cost of the drug less the applicable copayment and a 25% penalty.

Mail Order

		per 90-day supply
Tier 1	Generic drugs	$25
Tier 2	Formulary brand name drugs	$62.50
Tier 3	Non-formulary brand name drugs	$100

If you use the PrimeMail® Mail Service Pharmacy Program, you may order up to a 90-day supply of your maintenance medication at one time (if allowed by your prescription).

Prescription drug benefits are subject to limitations and exclusions. For further information about the drug formulary or your prescription drug coverage, please refer to the certificate of coverage.

Inpatient & Outpatient Hospital & Skilled Nursing Facility Benefits

Benefits are available for the following covered services:

- Semiprivate room; cardiac and intensive care units; treatment rooms and equipment.
- Anesthesia.
- Respiratory care.
- FDA-approved drugs, intravenous solutions and vaccines administered in the hospital.
- Chemotherapy.
- Radiology, pathology and radiation therapy.
- Physical, occupational and speech therapy.
- Inpatient physical rehabilitation, subject to a 60-day per calendar year benefit maximum, preauthorization and certain requirements.

Skilled Nursing Facility Benefits

Benefits for physician-ordered covered services in a licensed skilled nursing facility are available, up to 60 days per calendar year, subject to medical necessity criteria.

Outpatient Hospital Benefits

Benefits for the medically necessary services listed under "Inpatient Hospital & Skilled Nursing Facility" are also available (subject to certain limitations) when they are received in a hospital outpatient department, emergency room or freestanding ambulatory surgical facility.

Benefits for outpatient cardiac and pulmonary rehabilitation are available, subject to a $15 copay per outpatient session when services are received in-network. Out-of-network benefits are subject to deductible and coinsurance. Benefits for cardiac and pulmonary rehabilitation are each subject to an 18-session per calendar year maximum.

Physician Benefits

Physician Office Visits

When you go to a network physician, you pay a $15 copay for diagnostic and routine office visits/consultations and allergy injections. Benefits for the balance of covered services are paid at 100% of the allowable charge. When an out-of-network physician is used, benefits are subject to deductible and coinsurance.

Routine/Preventive Care Benefits

When in-network providers are used, covered routine services are paid at 100% of the allowable charge. If out-of-network providers are used, benefits for covered services are subject to deductible and coinsurance amounts. Benefits for the office visit charge are subject to a $15 copay (see previous section).

Benefits are also available for the following covered services:

- Surgery and surgical assistance (for specified procedures).
- Anesthesia.
- Radiation therapy and chemotherapy.
- Diagnostic services in the physician's office.

Maternity & Newborn Coverage

Maternity coverage is available to subscribers and covered spouses and daughters. Obstetrical benefits include prenatal and postnatal care.

Coverage begins at birth for eligible dependent children if the employee has an employee & children or family membership in effect. If the employee has a single or employee & spouse membership in effect, coverage will begin at birth for the newborn if the employee requests a change to either employee & children or family membership within 31 days of the birth and pays any additional premium necessary.

Benefits for covered newborn care include hospital room and board, screening tests, physician services while hospitalized and other medically necessary treatment.

Oral Surgery

Benefits are available for the following covered services:

- Incision and drainage of abscesses and other non-surgical treatment of infections.
- Removal of tumors and cysts.
- Invasive surgical procedures of the jaw, not related to TMJ.
- Bone grafts to the jaw.
- Dental implants related to trauma, if provided within 12 months of the injury.
- Osteotomies to treat gross congenital jaw abnormalities.
- Treatment of natural teeth within 12 months of an accidental injury not related to eating, biting or chewing.
- Diagnosis, surgery and treatment of the temporomandibular joint (TMJ), up to a $2,500 contract maximum per covered person.

Mental Illness and Substance Abuse Treatment

Coinsurance for mental illness (except for serious mental illness) and substance abuse treatment does not apply toward the calendar year out-of-pocket maximum.

Serious mental illness is defined as any mental health condition that current medical science affirms is caused by a biological disorder of the brain and that substantially limits the life activities of the person with mental illness. Serious mental illness includes, but is not limited to: schizophrenia, schizoaffective disorder, delusional disorder, bipolar affective disorder, major depression or obsessive-compulsive disorder. Serious mental illness does not include substance abuse.

Inpatient Treatment

Inpatient benefits for treatment of a non-serious mental illness and/or substance abuse are subject to a 30-day calendar year maximum.

Outpatient Treatment

In-network benefits are subject to a $15 copay; out-of-network benefits are subject to deductible and coinsurance. Outpatient benefits for treatment of a non-serious mental illness and/or substance abuse are subject to a 20-unit calendar year maximum.

Organ & Tissue Transplants

Benefits are available for medically necessary organ and tissue transplants, including (but not limited to): liver, heart, lung, heart-lung, kidney, pancreas, pancreas-kidney, small bowel, stem cell and cornea. Limited benefits are also available for allogeneic/autologous bone marrow transplants for the specific conditions listed in the contract.

Skilled Nursing and Hospice Care

These covered services require benefit preauthorization. Limitations and exclusions apply.

Skilled Nursing Care

Benefits are available for medically necessary physician-ordered skilled nursing care in the home by a registered or licensed practical nurse, up to eight hours per day. Benefits are subject to a 60-visit maximum each calendar year.

Hospice Care

Benefits include home health aide services for a terminally ill patient, including nursing services, medical social worker visits and crisis care. Benefits are subject to a 360-day/visit contract maximum.

Other Covered Services

Emergency Room Benefits

Benefits for covered services received in a hospital emergency room are payable at 100% of the allowable charge, subject to a $100 copay per visit. This copay is waived if the patient is admitted as an inpatient within 24 hours for the same diagnosis.

Benefits for covered emergency room physician charges are payable at 100% of the allowable charge.

Urgent Care Facility Benefits

Benefits for covered urgent care facility services (excluding maternity services) are subject to a $35 copay per visit.

Benefits are also available for the following covered services:

- Ambulance services, subject to the in-network deductible and coinsurance amounts.
- Routine vision exams, including refractions. In-network benefits are subject to a $15 copay; out-of-network benefits are subject to deductible and coinsurance.
- Outpatient occupational therapy, physical therapy, speech therapy/cognitive training and chiropractic/osteopathic physiotherapy, up to a combined benefit maximum of 75 therapy sessions per calendar year. In-network benefits are subject to a $15 copay per visit; out-of-network benefits are subject to deductible and coinsurance.
- Pediatric immunizations through age 6. When an in-network provider is used, benefits are paid at 100% of the allowable charge. Out-of-network benefits are subject to coinsurance only (deductible waived).
- Rental or purchase of medically necessary home medical equipment, subject to a $2,500 calendar year benefit maximum.
- Diabetes outpatient self-management training and patient management from an approved provider; podiatric appliances. When an in-network provider is used, diabetes education benefits are subject to a $15 copay per visit. Out-of-network benefits are subject to deductible and coinsurance.

- Administration of blood, plasma, derivatives and fractionates.
- Services in accordance with the Women's Health and Cancer Rights Act, which requires that a group health plan providing medical and surgical benefits for mastectomies also provide benefits for breast reconstruction, prostheses and treatment of physical complications.

Noncovered Services

This document contains only a partial listing of the limitations and exclusions that apply to this health care coverage. A more complete list may be found in the master group contract held by your employer, or by referring to the certificate of coverage and schedule of benefits.

No benefits are available for the following:

- Services not covered by this contract.
- Routine hearing exams (except newborn); hearing aids and their fitting.
- Eyeglasses, contact lenses, eye exercises or visual training.
- Custodial care.
- Treatment for weight reduction/obesity, including surgical procedures.
- Artificial insemination; invitro fertilization; infertility treatment, and related testing.
- Services, procedures, supplies or drugs for treatment of sexual arousal disorders or erectile dysfunction, regardless of cause.
- Massage therapy performed by a massage therapist.
- Residential treatment programs for treatment of mental illness and/or substance abuse.
- Services Blue Cross and Blue Shield of Nebraska considers investigative, not medically necessary, experimental, cosmetic, or obsolete.
- Services, drugs, medical supplies, devices or equipment that are not cost effective compared to established alternatives or that are provided for the convenience or personal use of the patient.
- Nutrition care, supplies, supplements or other nutritional substances, including Neocate, Vivonex and other over-the-counter nutritional supplements.
- Treatment of hyperhidrosis.
- Radial keratotomy or any other procedures/alterations of the refractive character of the cornea to correct myopia, hyperopia and/or astigmatism.
- Services for any bone marrow transplants not specifically listed in the contract as covered.
- Treatment of gynecomastia.
- Charges in excess of our contracted amount.
- Services provided before the coverage effective date or after termination.
- Services for illness or injury sustained while performing military service.
- Services for illness or injury resulting from war or act of war, declared or undeclared.
- Services, procedures, treatment, drugs or supplies received outside the U.S. or its territories when the reason for traveling was to obtain the services, procedures, treatment, drugs or supplies.
- Charges for services which are not within the provider's scope of practice.
- Services for illness or injury arising out of or in the course of employment.
- Charges made separately for services, supplies and materials considered to be included within the total charge payable.

General Information

Special Enrollment Period

A special enrollment period of 31 days is allowed for:

- enrollment due to marriage, birth or adoption.
- eligible persons not previously covered under the plan because of other coverage at the time of initial eligibility and who have lost that coverage due to:
  - exhaustion of coverage under a COBRA continuation provision; or
  - a loss of eligibility, including a loss due to death, divorce, termination of employment or reduction in work hours; or the employer ceased to make contributions for the other coverage.

Late Enrollment

A "late enrollee" is defined as an employee or dependent for whom coverage is not requested within 31 days of his or her initial eligibility or during a special enrollment period. Late enrollment is allowed only during the month of December, one month prior to the group's annual renewal date of January 1.

You or your eligible dependents are not considered late enrollees if:

- you and/or your dependent were covered under other qualifying previous coverage at the time of your initial eligibility for this group coverage; and
- you and/or your dependent lost coverage under the qualifying previous coverage as a result of: termination of employment or reduction of work hours; termination of eligibility; death of a spouse; divorce or legal separation; the exhaustion of COBRA; and
- you and/or your eligible dependent request enrollment within 31 days after termination of the qualifying previous coverage; or
- a court has ordered coverage be provided for a spouse or dependent under your coverage and the request for enrollment is made within 31 days after issuance of the order.

Types of Enrollment

Single Membership: Covers the employee only.

Employee & Spouse: Covers the employee and his or her spouse, but no children.

Employee & Children: Covers the employee and his or her eligible dependent children, but does not cover a spouse.

Family Membership: Covers the employee, his or her spouse, and all eligible dependent children.

"Eligible dependent children" include biological and adopted children, stepchildren and children under court-appointed guardianship. Grandchildren are also considered eligible dependents if the employee has adopted or assumed legal guardianship over them and they live with the employee in a regular child-parent relationship. Foster children are not considered eligible dependents.

Eligible dependent children are covered through 18 years of age, or through 23 years of age if full-time students attending an accredited educational institution. Physically or mentally handicapped children may be eligible for continuous coverage after age 18 if application is made within 31 days of the child's 19th birthday. Students who become disabled after age 19 will be eligible for continuous coverage if the student is incapable of attending school due to a mental or physical handicap.

IMPORTANT NOTE

This document contains only a partial description of the benefits, limitations, exclusions and other provisions of the master group contract to which it refers. It should be considered a general summary only, and should not be considered to be the master group contract or any part of the master group contract.

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